BOARD OF COMMUNITY HEALTH
November 10, 2004

The Board of Community Health held its regularly scheduled meeting in the Floyd Room, 20th Floor, West Tower, Twin Towers Building, 200 Piedmont Avenue, Atlanta, Georgia. Board members attending were Jeff Anderson, Chairman; Richard Holmes, Vice Chairman; Frank Rossiter, M.D., Secretary; Lloyd Eckberg; Inman English, M.D.; Ann McKee Parker, Ph.D.; Kent (Kip) Plowman; and Chris Stroud, M.D. Commissioner Tim Burgess was also present. (A List of Attendees and Agenda are attached hereto and made official parts of these Minutes as Attachments # 1 and # 2).

Mr. Anderson called the meeting to order at 10:12 a.m. and asked each board member to introduce himself/herself. The Minutes of the October 13 meeting were UNANIMOUSLY APPROVED AND ADOPTED.

Mr. Anderson called on Commissioner Burgess to make his report. Commissioner Burgess began his report about discussing the Medicaid eligibility system. The Department released a RFP several months ago and recently signed a contract with a consulting firm who will work with the DCH and the Department of Human Resources for the next three months to perform an in-depth review and assessment of the eligibility system. The Department expects a first report from the consultant in January and a final report in March. The Commissioner will give an update in January on the findings and maybe some suggestions on how DCH and DHR might go about strengthening that effort. Commissioner Burgess stated that the Department's budget hearing has been scheduled for December 3 with the Governor and his staff and the Office of Planning and Budget to discuss both the State Health Benefit Plan and Medicaid budgets for FY 2005 and 2006. Commissioner Burgess reported that the public hearing for the Proposed Certificate of Need Rules will be held November 22. The Department will bring to the Board at the December meeting recommendations for final passage of those rules. Lastly, Commissioner Burgess stated that the Department is in the process of selecting a location for the January and February meetings.

Mr. Anderson asked for a board discussion on board operation and committee structure. Mr. Anderson called on Neal Childers, General Counsel, to discuss committee structure. Mr. Childers said that he prepared for the board's consideration a proposed resolution that would create four new committees within the board structure. Under the board's bylaws no specific standing committees are spelled out; however, the bylaws do contemplate committees and provide for the chairman to name the chairman and members of each committee the board establishes as well as serve on each committee as an ex-officio member. The four standing committees that the resolution proposes to create would continue independently in existence until it is determined that that particular committee's work is concluded. Mr. Eckberg MADE THE MOTION to propose a resolution to provide for the creation of standing committees. Dr. Rossiter SECONDED THE MOTION. After further questions and discussion from the Board, Mr. Anderson asked Mr. Childers to read the proposed resolution. Mr. Plowman MADE THE MOTION to APPROVE the resolution to authorize the Chairman of the Board to appoint members to serve on committees to more efficiently carry out the business of the board. Dr. Rossiter SECONDED THE MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. The standing committees are: Audit, Care Management, Executive, and Legislative Committees. (A copy of the resolution is attached hereto and made an official part of these Minutes as Attachment #3.)

Mr. Anderson called for public comment. Ms. Ruth Ellen Roberts, a speech-language pathologist of Walton County gave public comment.

Commissioner Burgess stated that since September, the Department has been holding stakeholder sessions and thought it important to share with the Board and the public, concerns, suggestions and ideas expressed at the stakeholder meetings on how the Department should build the RFP and contract and move into a managed care environment. Mr. Anderson called on Kathy Driggers, Chief, Managed Care and

Quality, to give a Medicaid Managed Care update. Ms. Driggers began by stating that in late August the Governor unveiled his plan to change the way healthcare is delivered to Medicaid members and paid for by the state. The Department began with a legislative leadership meeting on August 23 and then met with a statewide group of professional organizations and advocacy groups at the Governor's Mansion on August 24. The goals of the reform effort are to improve members' healthcare status; establish contractual accountability for access to and quality of healthcare and lower the state's cost through more effective utilization management; and gain budget predictability and administrative simplicity. The Department held a series of 17 meetings in the last two months with over 375 people attending; that translates into 40 hours of meetings with follow up still ongoing. The Department tried to include all professional organizations that represent stakeholders, advocacy groups, DHR, and many constituencies. A number of universal themes came out of those meetings. One area of concerned expressed was the governance of the CMO plan. The Department was asked to monitor these plans vigilantly and require liquidated damages for infractions of any of the contractual responsibilities; consider pooling liquidated damages and return some of that to providers that have been aggrieved by the plans and some of those processes if they are meeting their contractual standards; provide avenues for providers to come directly to the State with plan issues; limit or cap the amount of profitability that plans make and reinvest program savings back into the healthcare infrastructure. Another universal theme heard from almost everyone was the desire to have their services carved out in some manner; continue on a fee-for-service basis statewide directly from the Department; carving out one region from the managed care approach and possibly letting a group of providers try a different methodology in that region or let that region be paid directly from the state; and use a pilot approach in certain areas to carve out a service. Staff heard a tremendous amount about member issues. Universal concerns were: access to healthcare services may be reduced; member outreach and education is extremely important; the plans should take on more responsibility for educating members about Medicaid and responsibility for their healthcare; inappropriate emergency room utilization; create an ombudsman function for mental health; concerns that CMO plans may deny needed healthcare services to members; DCH needs to more strictly enforce eligibility; and plans should require cost-sharing by members. The next category of issues dealt with provider payment issues. There was a lot of concern voiced about how providers would be paid; a reluctance to be subcapitated; questions about how far down that capitation reimbursement would extend; concerns about reimbursement levels for out-of-network providers; plans using administrative denials and administrative hassles and interfere with a provider's cash flow; desire for DCH to require a higher degree of standardization from the plan; establish a definition of a clean claim to comply with the Georgia Prompt Payment laws; fear that plans will reduce the reimbursement fees; and a desire for the state to become the guarantor if a plan becomes insolvent. The next universal group of issues was provider network issues. Concerns expressed by almost every group was that traditional community providers would be excluded from the networks; the desire for DCH to mandate "any willing provider" networks to any of its CMO vendors; an appropriate number and mix of specialist and sub-specialist; real concern about Medicaid members having to travel a great distance to see specialist; a desire for specialists to serve as primary care physicians in rural areas; strong interest in plans having a local physician advisory committee so that local input could be given into the utilization management; concern about a clear and appropriate provider appeal process related to CMO activities; mandate consistent utilization management strategies across all plans; concerns about administrative complexity; and DCH should not allow Medicaid members to seek healthcare outside the state for services that are provided in the state. In the area of pharmacy, concerns were heard about the fear of lowered dispensing fees; the state loss of potential pharmacy rebates associated with managed care; independent pharmacies fear they may lose their market share to larger chain pharmacies; interest in the provision of care management and some primary care services by pharmacists; and pharmacists felt strongly about not allowing mail-order pharmacy services. When the Department met with the Department of Human Resources, its staff expressed concerns about how would

county health departments fit into the new plan; how would DCH coordinate DHR's public health's care coordination into this new mode; concern about mental health and the future role of Community Service Boards; concerns about the impact on DFCS eligibility staff; and concerns about regional overlap with the Public Health districts. Ms. Driggers addressed questions and concerns from the Board.

Mr. Anderson called on Carie Summers, Chief Financial Officer, to discuss the Disproportionate Share Hospital and Indigent Care Trust Fund Hospital Payments Public Notice. Ms. Summers said that the Department brought this public notice to the Board at the August 25 meeting to make changes to the allocation methodology for the Disproportionate Share Hospital (DSH) payments that are made through the Indigent Care Trust Fund (ICTF). In September the Department asked the board to vote on the notice but there was no quorum present. At that time the Board heard comments from hospitals that were impacted and the Department was asked to review and make sure it had considered all the pertinent information to validate that the recommendations were appropriate. Ms. Summers briefly discussed the four changes. The first change is related to how the Department defines "rural" for allocation purposes. The second change relates to the interpretation of what are obstetric services for the purpose of a rural hospital providing obstetric services for qualification for DSH. The third change relates to a requirement by the Centers for Medicare and Medicaid Services, and that is hospital specific DSH limits have to consider prior UPL rate adjustments. Finally, the Department had proposed to change the allocation methodology for private rural hospitals. Instead of the receiving 100% of the DSH allocation, the Department had proposed to reduce it to 50%. The combination of the four changes is budget neutral to the Department. It was change number 4 that the Board received sole public comments. Ms. Summers gave a timeline of the review of change on item number 4. In October the Department sent a survey to the ICTF Advisory Committee members. DCH staff polled the members and sent them testimony of the persons who made comments at the September board meeting in addition to additional information the Department had received and asked them the question, "Does this information change your mind about this recommendation?" Fifty percent of the Advisory Committee members said yes; fifty percent said no. The Committee reconvened at the end of October and received testimony from eleven people— Representative Alan Powell, eight hospital representatives impacted by the change and two representatives of healthcare systems. Ms. Summers gave a summary of the testimonies. Those who were against the change had five areas of concern; 1. fifty percent reduction in allocation; 2. no change in allocation to public rural hospitals; 3. no access to other reimbursement supplements to help them cover the loss; 4. reduction would hurt liability costs; and 5. the general need for rural hospitals. Those that support the changes had two comments; 1. the static level of the DSH funding and allocation methodology helps rural hospitals at the expense of safety net facilities, and 2. all hospitals are seeing increases in uncompensated care and liability costs. The final vote was six members voted to not change the allocation methodology and three members voted to change it. Commissioner Burgess recommended that the Board delete change number 4 previously proposed in September and accept the recommendations of the ICTF Advisory Committee to leave the methodology as it is and is reflected in the revised public notice. Ms. Summers addressed questions from the Board. Dr. Parker MADE A MOTION to adopt the revised Disproportionate Share Hospital and Indigent Care Trust Fund Hospital Payments Public Notice as policy. Dr. Stroud SECONDED THE MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was ADOPTED with one dissenting vote by Dr. Rossiter. Mr. Plowman abstained from voting. (A copy of the revised Disproportionate Share Hospital and Indigent Care Trust Fund Hospital Payments Public Notice is attached hereto and made an official part of these Minutes as Attachment #4.)

Mr. Anderson began discussion on old business. He asked the Board to recognize past board members Mrs. Carol Fullerton and Dr. Stephanie Kong with a token of appreciation for their years of service to the Board and the State of Georgia.

Mr. Anderson opened the floor for new business. He asked the Department to present to the Board a timeline for Medicaid Managed Care procurement and an update on what other states have done in their managed care efforts. Mr. Anderson began discussion about a proposed amendment to the By-Laws of the Board of Community Health to change the meeting date. Mr. Anderson called on Neal Childers to discuss the proposed amendment. Mr. Childers said the current by-laws of the board spell out that the regular board meeting will be on the second Wednesday of each month; therefore, he drafted a proposed amendment to the by-laws for the board's consideration. The by-laws do require for the purpose of an amendment that the amendment be publicized at one meeting and automatically laid on the table and held over to the following meeting before being adopted. Mr. Anderson MADE A MOTION to publish the proposed amendment to the by-laws to change the board meetings to the second Thursday of each month at 1:00 p.m. beginning in January 2005. Mr. Plowman SECONDED THE MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (A copy of the Proposed Amendment to the By-Laws of the Board of Community Health is attached hereto and made an official part of these Minutes as Attachment #5.)

There being no further business to be brought before the Board at the November 10 meeting Mr. Anderson adjourned the meeting at 11:50 a.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE

_____ DAY OF _____, 2004.

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MR. JEFF ANDERSON
Chairman

ATTEST TO:

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FRANK ROSSITER, M.D.
Secretary

Official Attachments:

#1 – List of Attendees
#2 – November 10 Agenda
#3 – Board Resolution
#4 – Disproportionate Share Hospital and Indigent Care Trust Fund Hospital Payments Public Notice
#5 - Proposed Amendment to the By-Laws of the Board of Community Health